		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035048

Facility Name: Lake Shore Healthcare & Rehabilitation Centre

Address: 7200 N. Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 973-7200 **Fax #** (773) 973-7724

IDPA ID Number: 36-3690679

Date of Initial License for Current Owners: 28-July-1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-03 to 31-Dec-03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 30th March 2004 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	328	Skilled (SNF)	328	119,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,034	1,900	9,596	32,530	8
9	SNF/PED					9
10	ICF	59,112	4,134	138	63,384	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	80,146	6,034	9,734	95,914	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.12%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-March-1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 28th July 1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 328 and days of care provided 8,832

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cen # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	424,111	73,821	45,304	543,236		543,236		543,236			1
2	Food Purchase		517,829		517,829	(34,417)	483,412	(311)	483,101			2
3	Housekeeping	315,347	138,313		453,660		453,660		453,660			3
4	Laundry	165,215	25,382		190,597		190,597		190,597			4
5	Heat and Other Utilities			342,871	342,871		342,871		342,871			5
6	Maintenance	143,356	63,339	242,371	449,066		449,066	5,812	454,878			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,048,029	818,684	630,546	2,497,259	(34,417)	2,462,842	5,501	2,468,343			8
	B. Health Care and Programs											
9	Medical Director			46,500	46,500		46,500		46,500			9
10	Nursing and Medical Records	4,385,949	545,338	162,838	5,094,125		5,094,125		5,094,125			10
10a	Therapy			9,414	9,414		9,414		9,414			10a
11	Activities	164,930	54,250		219,180		219,180		219,180			11
12	Social Services	118,137	445		118,582		118,582		118,582			12
13	Nurse Aide Training			1,602	1,602		1,602		1,602			13
14	Program Transportation											14
15	Other (specify):* Dental Service*			7,766	7,766		7,766		7,766			15
16	**TOTAL Health Care and Programs**	4,669,016	600,033	228,120	5,497,169		5,497,169		5,497,169			16
	C. General Administration											
17	Administrative	191,624		482,160	673,784		673,784	(299,934)	373,850			17
18	Directors Fees											18
19	Professional Services			29,488	29,488		29,488	33,682	63,170			19
20	Dues, Fees, Subscriptions & Promotions			176,805	176,805		176,805	(129,981)	46,824			20
21	Clerical & General Office Expenses	317,794	55,100	184,359	557,253		557,253	82,253	639,506			21
22	Employee Benefits & Payroll Taxes			995,623	995,623	34,417	1,030,040	137,351	1,167,391			22
23	Inservice Training & Education			634	634		634		634			23
24	Travel and Seminar			5,373	5,373		5,373	17,794	23,167			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,656	40,656		40,656		40,656			26
27	Other (specify):* *Payroll Taxes (Sch VII)							23,453	23,453			27
28	**TOTAL General Administration**	509,418	55,100	1,915,098	2,479,616	34,417	2,514,033	(135,382)	2,378,651			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,226,463	1,473,817	2,773,764	10,474,044		10,474,044	(129,881)	10,344,163			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre #0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			133,064	133,064		133,064	328,211	461,275			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,894	40,894		40,894	150,122	191,016			32
33	Real Estate Taxes			434,317	434,317		434,317		434,317			33
34	Rent-Facility & Grounds			2,405,667	2,405,667		2,405,667	(2,400,000)	5,667			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,013,942	3,013,942		3,013,942	(1,921,667)	1,092,275			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		513,217	691,729	1,204,946		1,204,946		1,204,946			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,580	179,580		179,580		179,580			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		513,217	871,309	1,384,526		1,384,526		1,384,526			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,226,463	1,987,034	6,659,015	14,872,512		14,872,512	(2,051,548)	12,820,964			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,106)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(311)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(825)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,227)	21		24
25	Fund Raising, Advertising and Promotional	(188,244)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	8,281	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,303)	20		28
29	Other-Attach Schedule *Per page 5A attached*	(1,410)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (343,145)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	-1,708,403	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ -1,708,403		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ -2,051,548		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lake Shore Healthcare & Rehabilitation Centre

ID# 0035048

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Costs (Total)	$ (3,077)	6	1
2	Deferred Maintenance Costs (for the year)	1,667	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,410)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(311)	0	0	0	0	0	0	0	0	0	0	(311)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,410)	7,222	0	0	0	0	0	0	0	0	0	5,812	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,721)	7,222	0	0	0	0	0	0	0	0	0	5,501	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(299,934)	0	0	0	0	0	0	0	0	0	(299,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	33,682	0	0	0	0	0	0	0	0	0	33,682	19
20	Fees, Subscriptions & Promotions	(191,372)	61,391	0	0	0	0	0	0	0	0	0	(129,981)	20
21	Clerical & General Office Expenses	(105,946)	188,199	0	0	0	0	0	0	0	0	0	82,253	21
22	Employee Benefits & Payroll Taxes	0	137,351	0	0	0	0	0	0	0	0	0	137,351	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,794	0	0	0	0	0	0	0	0	0	17,794	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	23,453	0	0	0	0	0	0	0	0	0	23,453	27
28	**TOTAL General Administration**	(297,318)	161,936	0	0	0	0	0	0	0	0	0	(135,382)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(299,039)	169,158	0	0	0	0	0	0	0	0	0	(129,881)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre **#** 0035048 **Report Period Beginning:** 1-Jan-03 **Ending:** 31-Dec-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(44,106)	1,921	370,396	0	0	0	0	0	0	0	0	328,211	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	27,267	122,855	0	0	0	0	0	0	0	0	150,122	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,400,000)	0	0	0	0	0	0	0	0	(2,400,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(44,106)	29,188	(1,906,749)	0	0	0	0	0	0	0	0	(1,921,667)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(343,145)	198,346	(1,906,749)	0	0	0	0	0	0	0	0	(2,051,548)	45

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 172,767	$ 172,767	1
2	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	7,917	7,917	2
3	V	17	Management Fee Income	482,160	Lancaster, Ltd.	100.00%		(482,160)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	33,682	33,682	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	188,199	188,199	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	137,351	137,351	6
7	V	24	Education, Travel & Seminars		Lancaster, Ltd.	100.00%	17,794	17,794	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	9,459	9,459	8
9	V	20	Licenses, Fees and Marketing		Lancaster, Ltd.	100.00%	61,391	61,391	9
10	V	32	Interest	40,894	Lancaster, Ltd.	100.00%	68,161	27,267	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	1,921	1,921	11
12	V	6	Maintenance		Lancaster, Ltd.	100.00%	7,222	7,222	12
13	V	27	Payroll Taxes - Clerical		Lancaster, Ltd.	100.00%	15,536	15,536	13
14	Total			$ 523,054			$ 721,400	$ * 198,346	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental Income	$ 2,400,000	Lake Shore Associates	100.00%	$	$ (2,400,000)	15
16	V	30	Depreciation		Lake Shore Associates	100.00%	370,396	370,396	16
17	V	32	Interest	56,452	Lake Shore Associates	100.00%	179,307	122,855	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,456,452			$ 549,703	$ * (1,906,749)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ce # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	50%	see attached	14	29.17%	Lancaster	$ 99,547	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0%	see attached	13	27.08%	Lancaster	40,093	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0%	see attached	13	27.08%	Lancaster	33,127	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 172,767		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)478.3699
Fax Number: (773)478.1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 341,304	$ 341,304	14	$ 99,547	1
2	27	Laurence Zung	Hours Worked	48	7	11,443	0	14	3,338	2
3	17	Christopher Vicere	Hours Worked	48	7	148,036	148,036	13	40,093	3
4	27	Christopher Vicere	Hours Worked	48	7	8,641	0	13	2,340	4
5	17	Cheryl Morris	Hours Worked	48	7	122,314	122,314	13	33,127	5
6	27	Cheryl Morris	Hours Worked	48	7	8,268	0	13	2,239	6
7										7
8										8
9	19	Professional Services	Management Fees	1,974,210	7	137,913	0	482,160	33,682	9
10	21	Clerical Expenses	Management Fees	1,974,210	7	58,516	0	482,160	14,291	10
11	22	Employee Benefits	Management Fees	1,974,210	7	562,384	0	482,160	137,351	11
12	24	Education and Seminars	Management Fees	1,974,210	7	23,865	0	482,160	5,829	12
13	17	Administrative Consultant	Management Fees	1,974,210	7	38,732	38,732	482,160	9,459	13
14	20	Marketing	Management Fees	1,974,210	7	245,986	171,548	482,160	60,077	14
15	32	Interest	Management Fees	1,974,210	7	47,944	0	482,160	11,709	15
16	30	Depreciation	Management Fees	1,974,210	7	7,864	0	482,160	1,921	16
17	20	Licenses and Fees	Management Fees	1,974,210	7	5,379	0	482,160	1,314	17
18	6	Maintenance	Management Fees	1,974,210	7	29,570	0	482,160	7,222	18
19	24	Travel	Management Fees	1,974,210	7	48,990	0	482,160	11,965	19
20	21	Salaries - Clerical	Management Fees	1,974,210	7	712,068	712,068	482,160	173,908	20
21	27	Payroll Taxes - Clerical	Management Fees	1,974,210	7	63,611	0	482,160	15,536	21
22										22
23	32	Direct Interest							15,558	23
24										24
25	TOTALS					$ 2,622,828	$ 1,534,002		$ 680,506	25

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Cen # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank One		X	Commercial Loan	$30,000.00	5/1/02	$ 7,200,000	$ 6,780,000		2.48%	$ 179,307	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank One		X	Working Capital							11,709	6
7												7
8												8
9	TOTAL Facility Related				$30,000.00		$ 7,200,000	$ 6,780,000			$ 191,016	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,200,000	$ 6,780,000			$ 191,016	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	434,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	431,817	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,183)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	436,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	434,317	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	429,119	8
	1999	426,240	9
	2000	416,205	10
	2001	427,029	11
	2002	431,817	12

** Accrual is based on 2001 actual Taxes, adjusted for inflation**

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehabilitation Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035048

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-320-040-0000	Long-Term Healthcare	$ 26,495.78	$ 26,495.78
2.	11-29-320-039-0000	Long-Term Healthcare	$ 94,579.75	$ 94,579.75
3.	11-29-320-038-0000	Long-Term Healthcare	$ 94,735.55	$ 94,735.55
4.	11-29-320-037-0000	Long-Term Healthcare	$ 94,735.55	$ 94,735.55
5.	11-29-320-036-0000	Long-Term Healthcare	$ 94,341.50	$ 94,341.50
6.	11-29-320-035-0000	Long-Term Healthcare	$ 26,928.83	$ 26,928.83
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 431,816.96	$ 431,816.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1992	$ 740,000	1
2					2
3	TOTALS			$ 740,000	3

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	328		1992		$ 11,667,460	$ 370,396	40	$ 291,687	$ (78,709)	$ 3,354,401	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	24,908		10			24,908	9
10	Various			1990	80,814		10			80,814	10
11	Various			1991	28,469	3,279	20	1,114	(2,165)	20,447	11
12	Various			1992	12,856	408	20	643	235	7,357	12
13	Various			1993	68,862	1,789	20	3,444	1,655	36,157	13
14	Various			1994	5,698	146	20	286	140	2,807	14
15	Various			1995	76,433	1,767	20	3,822	2,055	33,288	15
16	Fire Alarm System			1996	54,450	1,396	20	2,723	1,327	21,784	16
17	Seamco Stone Deck			1996	7,989	205	20	399	194	2,926	17
18	Roof Exhauster			1996	2,700	69	20	135	66	967	18
19	Front Sign			1996	12,020	710	20	601	(109)	4,357	19
20	Water Heating System			1997	38,800	995	20	1,940	945	13,257	20
21	Fluorescent Conversion			1997	25,353	650	20	1,268	618	8,559	21
22	Elevator Improvement			1998	55,364	1,420	20	1,420		7,988	22
23	Electronic Alzheimer Doors			1998	11,800	303	20	303		1,603	23
24	Elevator Interiors			1999	34,422	883	20	883		3,863	24
25	Parking Lot Resurface			1999	20,240	1,457	20	1,457		7,127	25
26	Patio Stone Decking			1999	6,465	454	20	454		2,383	26
27	Electric Panel Board			2002	5,000	128	10	500	372	667	27
28	Parking Lot Fence			2003	19,707	9,948	10	821	(9,127)	821	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,259,810	$ 396,403		$ 313,900	$ (82,503)	$ 3,636,481	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 579,778	$ 41,105	$ 56,263	$ 15,158	10	$ 65,556	71
72	Current Year Purchases	109,908	64,678	76,322	11,644	10	76,322	72
73	Fully Depreciated Assets	1,644,322	3,195	14,790	11,595	10	1,644,322	73
74								74
75	TOTALS	$ 2,334,008	$ 108,978	$ 147,375	$ 38,397		$ 1,786,200	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,333,818	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 505,381	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 461,275	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (44,106)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,422,681	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ** N/A - Related Party Lease **

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	** Off-site Public Storage space **			5,667			4
5								5
6								6
7	TOTAL				$ 5,667 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	82

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	27.5

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 584	$	$ 584
2	Books and Supplies	227	341		568
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		450		450
9	TOTALS	$ 227	$ 1,375	$	$ 1,602
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,602			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	
TOTAL TRAINED	25

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 143,569	$		$ 143,569	1
2	Licensed Speech and Language Development Therapist		hrs			4,493			4,493	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			138,747			138,747	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				333,097		333,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program					17,135			17,135	12
13	**Ventilation/Inhalation Therapy ** Other (specify): *Supplies/Specialty Beds*					387,785	180,120		387,785 180,120	13
14	TOTAL			$		$ 691,729	$ 513,217		$ 1,204,946	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 **Report Period Beginning:** 1-Jan-03 **Ending:** 31-Dec-03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,334	$ 11,334	1
2	Cash-Patient Deposits	112,179	112,179	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,485,874	3,485,874	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,863	57,863	6
7	Other Prepaid Expenses	5,125	5,125	7
8	Accounts Receivable (owners or related parties)	72,507	374,855	8
9	Other(specify): **Refundable Deposits	3,218	3,218	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,748,100	$ 4,050,448	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		740,000	13
14	Buildings, at Historical Cost		11,667,460	14
15	Leasehold Improvements, at Historical Cost	553,958	557,958	15
16	Equipment, at Historical Cost	1,065,730	2,334,009	16
17	Accumulated Depreciation (book methods)	(1,093,658)	(6,610,058)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		217,904	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(217,904)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 526,030	$ 8,689,369	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,274,130	$ 12,739,817	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 333,102	$ 333,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	141,874	141,874	28
29	Short-Term Notes Payable	3,567,341	8,317	29
30	Accrued Salaries Payable	652,267	652,267	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,456	18,456	31
32	Accrued Real Estate Taxes(Sch.IX-B)	436,500	436,500	32
33	Accrued Interest Payable		8,407	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,149,540	$ 1,598,923	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		6,780,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,780,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,149,540	$ 8,378,923	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (875,410)	$ 4,360,894	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,274,130	$ 12,739,817	48

***(See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 861,100	1
2	Restatements (describe):		2
3	**Adjustment in Book Depreciation for Taxation**	54,646	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 915,746	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,606,156)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ** Treasury Stock **	(185,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,791,156)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (875,410)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,555,655	1
2	Restatements (describe):		2
3	**Adjustment in Book Depreciation for Taxation**	54,646	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,610,301	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	300,593	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ** Treasury Stock **	(550,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (249,407)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,360,894	24 *

*** This must agree with page 17, line 47, col 2.**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,634,311	1
2	Discounts and Allowances for all Levels	(2,320,210)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,314,101	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,300,806	6
7	Oxygen	147,546	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,448,352	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	13,770	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	259,256	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,679	19
20	Radiology and X-Ray	14,258	20
21	Other Medical Services	167,940	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 497,903	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	* Vending Commissions *	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,266,356	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,497,259	31
32	Health Care	5,497,169	32
33	General Administration	2,479,616	33
	B. Capital Expense		
34	Ownership	3,013,942	34
	C. Ancillary Expense		
35	Special Cost Centers	1,204,946	35
36	Provider Participation Fee	179,580	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,872,512	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,606,156)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,606,156)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Cash Basis Taxpaye

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,882	2,051	$ 77,419	$ 37.75	1
2	Assistant Director of Nursing	2,308	2,453	87,947	35.85	2
3	Registered Nurses	78,284	83,080	1,946,184	23.43	3
4	Licensed Practical Nurses	12,850	13,757	286,563	20.83	4
5	Nurse Aides & Orderlies	171,637	182,956	1,860,556	10.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,955	4,271	55,367	12.96	9
10	Activity Assistants	10,738	11,273	109,563	9.72	10
11	Social Service Workers	9,178	10,073	118,137	11.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,586	43,405	424,111	9.77	15
16	Dishwashers					16
17	Maintenance Workers	10,202	11,135	143,356	12.87	17
18	Housekeepers	36,686	39,638	315,347	7.96	18
19	Laundry	19,360	21,175	165,215	7.80	19
20	Administrator	2,013	2,277	86,994	38.21	20
21	Assistant Administrator	4,050	4,256	104,630	24.58	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,180	21,580	317,794	14.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,473	9,382	127,280	13.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	432,382	462,762	$ 6,226,463 *	$ 13.46	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	1,373	$ 45,304	1-3	35
36	Medical Director	949	46,500	9-3	36
37	Medical Records Consultant	112	4,472	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	525	7,872	10-3	39
40	Physical Therapy Consultant	272	9,414	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,231	$ 113,562		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,598	$ 125,662	10-3	50
51	Licensed Practical Nurses	646	24,832	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,244	$ 150,494		53

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James R. Farlee	Administrator	N/A	$ 86,994
Judith M. Lewis	Asst. Admn.	N/A	56,509
Joanne Ventrella	Asst. Admn.	N/A	48,121
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 191,624

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 482,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 482,160
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 1,870
Richard Peelo	Accounting	2,250
Stone, Pogrund & Korey	Legal	5,598
Panarese & Panarese	Legal	678
Elaine Douglas	Legal	750
Patricia Hogan	Legal	1,026
Accu-Med Services, Inc.	Data Processing	3,884
Medi, Inc.	Data Processing	783
AdminaStar Federal	Data Processing	571
Health Data Systems, Inc.	Data Processing	9,615
Medical Supply Co of Illinois	Data Processing	618
Personnel Planners	Payroll Tax Consultant	1,845
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,850
Unemployment Compensation Insurance	37,228
FICA Taxes	460,443
Employee Health Insurance	313,155
Employee Meals	34,417
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	10,340
Misc. Employee Benefits	44,858
Retirement Plan Contributions	16,115
Uniform Allowance	6,771
Holiday expenses	4,899
Employment Fees	28,964
Lancaster Allocation	137,351
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,167,391

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 8,560
Advertising: Employee Recruitment	7,349
Health Care Worker Background Check	
(Indicate # of checks performed 70)	756
Fingerprinting Checks	83
Promotional Advertising	130,470
Licenses & Fees	6,856
Dues & Subscription	22,731
Lancaster Allocation	61,391
Less: Public Relations Expense	(128,992)
Non-allowable advertising	(60,077)
Yellow page advertising	(2,303)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	854
Lancaster Allocation	11,965
Seminar Expense	4,519
Lancaster Allocation	5,829
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,167

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre # 0035048 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting and Decorating	Mar-97	$ 2,805	3	$ 468	$	$	$	$	$	$	$	$
2	Painting and Decorating	Apr-97	5,116	3	853								
3	Painting and Decorating	Aug-97	3,270	3	545								
4	Painting and Decorating	Mar-98	3,052	3	1,017	509							
5	Painting and Decorating	Aug-2001	674	3		113	224	224	113				
6	Painting and Decorating	Dec-2001	1,199	3		200	400	400	199				
7	Painting and Decorating	Jul-2002	113	3			20	37	37	19			
8	Painting and Decorating	Aug-2002	1,252	3			209	417	417	209			
9	Painting and Decorating	Nov-2002	229	3			39	76	76	38			
10	Painting and Decorating	Jan-Mar '03	664	3				111	221	221	111		
11	Painting and Decorating	Jul-Sept '03	1,012	3				168	338	338	168		
12	Painting and Decorating	Oct-Dec '03	1,401	3				234	467	467	233		
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 20,787		$ 2,883	$ 822	$ 892	$ 1,667	$ 1,868	$ 1,292	$ 512	$	$

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre **#** 0035048 **Report Period Beginning:** 1-Jan-03 **Ending:** 31-Dec-03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care-$14,422**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,744** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **179,580**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **34,417** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.